Medicare Supplement Insurance Program

Sponsored by the American Medical Association

AMA INSURANCE

IT'S EASY TO ENROLL:

1. Please complete, date and sign this form, and check the Plan you want. Make sure you answer all the questions and read all the statements.
2. Send NO MONEY at this time. You will be billed when your Insurance Certificate is mailed.
3. Return this Enrollment Form (be sure to have your spouse sign if also enrolling) in the postage-paid envelope provided to:
   AMA Insurance Agency, Inc.
   330 North Wabash Avenue, Suite 39300
   Chicago, IL 60611-5885.

Response Requested by:

This Medicare Supplement Enrollment Form for both Physician & Spouse

Administered by:
AMA Insurance Agency, Inc.
330 North Wabash Avenue, Suite 39300
Chicago, IL 60611-5885
(In California, d/b/a: AMA of Illinois Insurance Agency)
A Subsidiary of the American Medical Association

Underwritten by:
Transamerica Life Insurance Company
Cedar Rapids, Iowa

PLEASE COMPLETE

☒ **I wish to enroll**

Phone No. (_____) _____

_____
Name of Physician whose Spouse is enrolling for coverage.

_____
Spouse's Name (if enrolling)

_____
E-mail address

Please attach a copy of your Medicare ID card with this enrollment form to expedite electronic filing and speed the processing of your Part B claim.

Physician:

Social Security Number: _____-_____-_____

Date of Birth: _____/_____/_____ (Month/Day/Year)

Sex: ☐ Male ☐ Female

_____
Medicare ID Number *(Found on your Medicare ID Card)*

Desired future effective month (Month/Year): _____/_____

Spouse: (If enrolling)

Social Security Number: _____-_____-_____

Date of Birth: _____/_____/_____ (Month/Day/Year)

Sex: ☐ Male ☐ Female

_____
Medicare ID Number *(Found on your Medicare ID Card)*

Desired future effective month (Month/Year): _____/_____

Please read and complete the other side ▶

CHECK BOX FOR DESIRED COVERAGE:

Physician: ☐ Plan A ☐ Plan B ☐ Plan C[1] ☐ Plan D ☐ Plan F[1] ☐ Plan G ☐ Plan K ☐ Plan L ☐ Plan M ☐ Plan N

Monthly rate based on current age

Spouse: ☐ Plan A ☐ Plan B ☐ Plan C[1] ☐ Plan D ☐ Plan F[1] ☐ Plan G ☐ Plan K ☐ Plan L ☐ Plan M ☐ Plan N

[1]Please Note: Only applicants first eligible for Medicare before 2020 may purchase Plans C, F and high deductible F.

PLEASE BILL (Choose one):

☐ Quarterly ☐ Semi-annual ☐ Annual ☐ EFT Monthly (Electronic Funds Transfer)

Please note: Effective date will be disclosed on the Certificate Schedule Page.

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE AND BELIEF

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your enrollment form. PLEASE ANSWER ALL QUESTIONS.

	Physician	Spouse
1) Your Acceptance May be Guaranteed.		
a) Did you turn age 65 in the last 6 months?	☐ Yes ☐ No	☐ Yes ☐ No
b) Did you enroll in Medicare Part B in the last 6 months? If yes, what is the effective date?	☐ Yes ☐ No ____/____/____ mo day year	☐ Yes ☐ No ____/____/____ mo day year
2) Premium Assistance Questions. (Questions we are required to ask)		
a) Are you covered for medical assistance through California's Medi-Cal program? (NOTE TO APPLICANT): If you have a "Share of Cost" under the Medi-Cal program, please answer NO to this question. If yes,	☐ Yes ☐ No	☐ Yes ☐ No
b) Will Medi-Cal pay your premiums for this Medicare Supplement policy?	☐ Yes ☐ No	☐ Yes ☐ No
c) Do you receive any benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium?	☐ Yes ☐ No	☐ Yes ☐ No
3) Replacement Questions. (Answer only if you are replacing coverage)		
■ **Medicare Advantage:** a) If you had coverage from any Medicare plan other than the original Medicare within the past 63 days (for example, a Medicare Advantage Plan, or Medicare HMO, or PPO) fill in your start and end dates. If you are still covered under this plan leave "END" blank.	Start: _____ End: _____	Start: _____ End: _____
b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?	☐ Yes ☐ No	☐ Yes ☐ No
■ **Medicare Supplement:**		
a) Was this your first time in this type of Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No
b) Did you drop a Medicare Supplement policy to enroll in this Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No
c) Do you have another Medicare Supplement policy in force?	☐ Yes ☐ No	☐ Yes ☐ No
d) If so, with what company, and what plan do you have? Company: _____ Plan: _____		
e) If so, do you intend to replace your current Medicare Supplement policy with this policy?	☐ Yes ☐ No	☐ Yes ☐ No

Please read and complete the next page ▶

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE AND BELIEF

(Continued)	Physician	Spouse
■ **Other**		
a) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan)	☐ Yes ☐ No	☐ Yes ☐ No
b) If so, with what company, and what kind of policy? Company: _____ Plan: _____	Start: _____	Start: _____
c) What are your dates of coverage under the other policy? (If you are still covered by the other policy, leave "END" blank).	End: _____	End: _____

Notices to Applicant: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. You are not required to provide health information to apply for this Medicare Supplement insurance.

MEDICARE SUPPLEMENT INFORMATION TO CONSIDER

- You do not need more than one Medicare Supplement policy or certificate.
- If you purchase this Certificate you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medi-Cal or Medicaid and may not need a Medicare Supplement policy or certificate.
- If, after purchasing this certificate, you become eligible for Medi-Cal, the benefits and premiums under your Medicare Supplement certificate can be suspended, if requested, during your entitlement to benefits under Medi-Cal or Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal or Medicaid. If you are no longer entitled to Medi-Cal or Medicaid, your suspended Medicare Supplement certificate (or, if that is no longer available, a substantially equivalent policy or certificate) will be reinstituted if requested within 90 days of losing Medi-Cal or Medicaid eligibility. If the Medicare Supplement certificate provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your certificate was suspended, the reinstituted certificate will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare Supplement certificate or policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement certificate or policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement certificate or policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent certificate or policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement certificate or policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medi-Cal or Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-income Medicare Beneficiary (SLMB). Information regarding counseling services may be obtained from the California Department of Aging.
- Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a crime and may be subject to fines or confinement in prison.

1-866-605-5708 **For more information, call this toll-free number for prompt, courteous service. Experienced, knowledgeable service specialists will gladly assist you. Monday through Friday, 8:00 a.m. to 5:00 p.m., Central Time.**

Please read the next page ▶

IMPORTANT - PLEASE READ AND SIGN

I hereby enroll for Medicare Supplement coverage issued by Transamerica Life Insurance Company. I understand that this coverage will not pay benefits for conditions for which I have received medical treatment or advice within the last 6 months prior to the effective date until I have been insured for 6 consecutive months. If I had creditable health insurance coverage within 63 calendar days of enrolling in this plan, or if I am an Eligible Person enrolled within 63 days of termination then this pre-existing conditions limitation will be waived to the extent that it was satisfied under the replaced coverage. This waiver will apply only to prior creditable coverage which includes, but is not limited to, coverage under a group health plan, health insurance coverage, Medicare Supplement, Medicare Parts A and B, Medicaid, TRICARE, a state health benefits risk pool or the Federal Employees Health Benefits Plan (FEHB).

PLEASE NOTE: If you are currently enrolled in a Medicare Risk HMO plan, you are responsible for terminating your HMO coverage once you apply for this plan. Any unpaid claims resulting from failure to disenroll from your HMO plan will be your responsibility.

I understand that my acceptance into this AMA-sponsored Plan is GUARANTEED with no medical information required and that the pre-existing condition limitation is not applicable if 1.) I enroll within 6 months of being age 65 (or older) and enrolled in Medicare Parts A and B or, 2.) if I have been covered by the AMA-sponsored Catastrophic Major Medical or Hospital Income Plan for at least the 12 months prior to the date this Medicare Supplement takes effect.

If you are age 65 or older, enrolled in Medicare Parts A and B and your premium is paid when due, your coverage will be effective on the first day of the month after your enrollment form is received by AMA Insurance Agency, Inc. (or on the first day of the following month if received on the 11th of the month or later).

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a crime and may be subject to fines or confinement in prison.

I acknowledge that I have read all statements:

Physician's Signature X _____ Date _____

Spouse's Signature X _____ Date _____

Your 30-Day Right to Return Your Certificate Takes the Risk Out of Enrolling Now

Enroll today. When your Certificate arrives, examine it carefully. Take up to 30 days, if you like, to discuss it with your family, friends, lawyer, accountant or advisor. If, for any reason, you decide during the 30 days that you do not need this supplemental protection, write "cancel" across the face of your Certificate and mail back to AMA Insurance Agency, Inc. Any premium paid will be refunded in full and your Certificate will be considered never issued.

1-866-605-5708 **For more information, call this toll-free number for prompt, courteous service. Experienced, knowledgeable service specialists will gladly assist you. Monday through Friday, 8:00 a.m. to 5:00 p.m., Central Time.**

Underwritten by Transamerica Life Insurance Company under Group Policy No. MS9000GPT

Please read and complete the other side if EFT Monthly (Electronic Funds Transfer) is desired